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Supreme Court, U.S.
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No. 08-511

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IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA, *ex rel.*,
RICHARD FEINGOLD,

Petitioners,

v.

PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS, BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA, and UNKNOWN DURABLE MEDICAL EQUIPMENT SUPPLIERS,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

ATLEE W. WAMPLER, III
Counsel of Record
WAMPLER BUCHANAN WALKER
CHABROW BANCIELLA & STANLEY, P.A.
SunTrust International Center
Suite 1700
One Southeast Third Avenue
Miami, Florida 33131
(305) 577-0044

SIDNEY R. BERGER
Three First National Plaza
Suite 3700
70 West Madison Street
Chicago, Illinois 60602
(312) 558-6730

Counsel for Petitioners

218483

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

QUESTION PRESENTED

Whether the Eleventh Circuit's decision granting absolute immunity to Medicare Carriers, like the Defendants in this case, was correctly decided in view of the flatly contrary conclusion reached by the Tenth Circuit in *United States ex rel. Sikkenga v. Regence BlueCross BlueShield*, 472 F.3d 702 (10th Cir. 2006).

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OPINIONS BELOW

The opinion of the Eleventh Circuit, dated May 20, 2008 is unpublished. (App. A) The district court order granting the respondents' motion to dismiss, dated January 30, 2007, is published. (App. B)

JURISDICTION

The district court had jurisdiction pursuant to 28 U.S.C. § 1331. The Court of Appeals had jurisdiction to review the district court's final judgment pursuant to 28 U.S.C. § 1291. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1), as the Eleventh Circuit denied a timely petition for rehearing on July 18, 2008, which is unpublished. (App. C)

STATUTES INVOLVED

Medicare's statutory immunity provision at issue in the case reads as follows:

> (1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.
>
> (2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was

> based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.
>
> (3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

42 U.S.C. § 1395u(e) (1999)

The federal False Claims Act imposes liability, inter alia, on any person who

> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
>
> (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid.

31 U.S.C. § 3729(a)(1)&(2).

SUMMARY AND INTRODUCTION

The Defendants have been protected from a knowing violation of the Federal False Claims Act by a plainly incorrect interpretation of the immunity provisions of the federal Medicare law. More specifically, the Eleventh Circuit clearly, and wrongly, interpreted the immunity provisions of the Medicare law as providing absolute immunity to Medicare contractors, like the

Defendants, when both the statutory language and the applicable legislative history indicate that Medicare contractors are only to be provided immunity in the absence of "gross negligence or intent to defraud" the Medicare program. The error in statutory interpretation made by the Eleventh Circuit is amply demonstrated by the flatly contrary conclusion reached by the Tenth Circuit in its unanimous decision in *United States ex rel. Sikkenga v. Regence BlueCross BlueShield,* 472 F.3d 702 (10th Cir. 2006),[1] which was urged and supported by an Amicus Curie Brief filed by the United States Department of Justice. (Amicus Brief of the United States Department of Justice in *United States ex rel. Sikkenga v. Regence Blue Cross Blue Shield of Utah*, July 22, 2005.)

The United States Department of Justice has recognized that the issue is "significant." (Amicus Brief of the United States Department of Justice in *United States ex rel. Sikkenga v. Regence Blue Cross Blue Shield of Utah*, July 22, 2005 at 20 n.7.) Indeed, the potential loss to the taxpayers as a result of the Eleventh Circuit's obvious error goes far beyond the $40,000,000 at stake in this litigation. There can be little doubt that there have been billions of dollars illegally paid by Medicare contractors like the Defendants, and some estimates have placed the extent of Medicare fraud as high as seventy billion dollars each year. The taxpayers should not be expected to pay that bill, and obvious "bad actors" like the Defendants should not get a free pass for their actions.

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[1] While Judge Hartz dissented with part of the majority opinion, he concurred that Medicare contractors were not entitled to absolute immunity.

COURSE OF PROCEEDINGS AND DISPOSITION OF THE CASE

This case is a False Claims Action brought under Section 3729(a) of the federal False Claims Act. Counts III and IV of the Amended Complaint address Medicare claims illegally paid to suppliers by the Defendants acting collectively as an administrative agent for the Medicare Program. (R 70, Amended Complaint ("AC") ¶¶ 201, 205.) The Relator, Richard Feingold (hereinafter the "Relator" and/or "Feingold") undertook a personal investigation of fraudulent supplier claims for Female Urinary Collection Pouches, (hereinafter, "FUCPs") submitted to the Defendant Palmetto, a Medicare Part B payment agent (or "Carrier") (hereinafter "Palmetto" and/or "BCBS/SC") (collectively the "Defendants"). (R. 70, AC at ¶ 69, 70, 71). Feingold's investigation revealed that Palmetto had fraudulently approved over $40 million in such claims for FUCPs. (R. 126, AC at ¶ 113.) Beginning in 1994 Defendant Palmetto was the Durable Medical Equipment (DME) Regional Carrier for the South East Region (hereinafter, "DMERC"), and as such was reimbursed by Medicare for their payments to suppliers of DME including FUCPs.

By 1997 Palmetto was the only DMERC paying FUCP claims. (R 70, AC ¶¶ 116-122.) Almost all of the claims approved by Defendants for FUCPs since 1994 were illegally paid. (R 70, AC ¶ 124.)

The Relator filed this Qui Tam False Claims Action under seal on March 31, 1999. The seal was partially

lifted, and on May 11, 2000 the Department of Justice sent the initial Complaint to the Defendants. (R 70, AC ¶ 140.) Only after being shown the Relator's initial Complaint did the Defendant Palmetto's conduct undergo a significant change. Specifically, Defendants went from approving almost all claims for FUCPs to immediately disapproving virtually all (over 99%) of the claims for FUCPs (HCPCS Code A4328) submitted to them for payment. (R 70, AC ¶ 140.) (In contrast, during the first six months of 2000 Defendant Palmetto had approved 95.5% of the claims for FUCPs submitted to it. (R 70, AC ¶ 141.)).

The Government declined to intervene on September 28, 2005. On January 20, 2006 an Amended Complaint was filed under seal. On March 1, 2006, the district court ordered the Amended Complaint to be unsealed. The Amended Complaint was served on the Defendants on March 2, 2006. On March 5, 2006, the Government again declined to intervene.

Counts I and III of the Amended Complaint were brought under 31 U.S.C. § 3729(a)(1). (R 70, AC ¶¶ 191, 199.) Counts II and IV were brought under 31 U.S.C. § 3729(a)(2). (R 70, AC ¶¶ 195, 203.) On April 17, 2006, the Defendants filed a Motion to Dismiss on multiple grounds. On January 30, 2007, the district court dismissed the case with prejudice without leave to amend. (R 126, District Court Order, Appendix B at 18.) The district court dismissed Counts III and IV on the basis of the absolute statutory immunity the district court concluded was required by the Medicare Law.

(R 126, District Court Order, Appendix B at 8-11).[2] A timely appeal followed on March 1, 2007.

On May 20, 2008 a Panel of the Eleventh Circuit determined that Counts III and IV of the Amended Complaint should be dismissed. (Appendix A.) The Panel

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[2] The district court also dismissed all Counts of the Amended Complaint as failing to satisfy the requirements of Fed. R. Civ. P. 9(b). (R 126, District Court Order at 17.) The district court stated that

> "[i]n his Complaint, consisting of 214 paragraphs over 116 pages, Feingold includes a wealth of information concerning the history of the FUCP scheme. He similarly provides allegations concerning the ways in which claims are processed and submitted from health care providers to carriers, and from carriers to the government. He fails, however to point so [sic] specific examples of fraudulent claims approved or submitted by Palmetto."

U.S. Ex Rel Feingold v. Palmetto, 477 F. Supp. 2d 1187, 1195 (S. D. Fla. 2007). However, the Amended Complaint did allege that the claims payment data obtained by Feingold from the government revealed that the total payments for FUCP claims authorized by Defendants in 1995 was more than 25 times the amount of money paid by Medicare under that Code in 1992 for the entire United States. (R 70, AC ¶ 114.). From the beginning of 1997 through the second quarter of 2000, Defendant Palmetto was virtually the only Medicare Durable Medical Equipment (DME) Regional Carrier in the country approving any payments for FUCPs, paying 99.9% of all such claims on behalf of the Medicare program. (R 70, AC ¶¶ 116-122.).Almost all of the claims approved by Defendants for FUCPs since 1994 were fraudulently paid. (R 70, AC ¶ 124.)

held that its decision was controlled by the absolute immunity previously established by another panel of the Eleventh Circuit in the earlier case of *United States ex rel. Body v. Blue Cross and Blue Shield of Ala., Inc.* 156 F.3d 1098 (11th Cir. 1998) ("*Body*").[3] On July 18, 2008 the Eleventh Circuit denied Petitioners Petition for Rehearing and Rehearing En Banc regarding the application of absolute immunity protection to the defendants with respect to Counts III and IV of the Amended Complaint. (Appendix C.)

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[3] The Eleventh Circuit Panel also held that Counts I and II of the Amended Complaint did not satisfy the requirements of Rule 9(b), but, unlike the district court, the Panel did not hold that Counts III and IV failed to satisfy the requirements of Fed. R. Civ. P. 9(b). In any case, the allegations of the Amended Complaint, which establish that Medicare paid out millions of dollars on false FUCP claims submitted by the Defendants, more than satisfies the requirements of Rule 9 (b). Moreover, this Court recently has held that

> "[w]hat Section 3729 (a)(2) demands is not proof that that the defendant caused a false record or statement to be presented or submitted to the Government but that the defendant made a false record or statement for the purpose of getting 'a false or fraudulent claim paid or approved by the Government.'"

Allison Engine Co. Inc., et al., v. U.S. ex rel. Sanders, 128 S. Ct. 2123 (2008). The millions of dollars in false claims submitted to the Government by the Defendants, and actually paid by the Government, based on the submissions of the Defendants, surely satisfies that requirement as well.

FACTS

The Amended Complaint alleges that the Defendants, acting as a Part B agent, or DMERC, for the federal Medicare Program, knowingly made fraudulent payments to Medicare suppliers for FUCPs from 1994 through the second quarter of 2000. The Relator's (Feingold's) first hand efforts revealed that FUCPs are virtually never ordered by physicians because they are more costly and less effective than indwelling catheters. FUCPs were subject to spillage and can result in an unsterile patient smelling of urine, whereas catheters avoid those problems. (R 70, AC ¶ 132.)

Feingold's investigation included requesting specific Medicare claims payment data from a Medicare employee concerning billing and payment for FUCPs. (R 70, AC ¶¶ 105, 106; R 126) Based upon his personal knowledge and experience, he was able to organize and analyze the requested information, and thereby confirm that the Defendant Palmetto was fraudulently approving patently false FUCP claims submitted to them for reimbursement from Medicare. (R 70, AC at ¶¶ 124, 128; See R 126.)

The data requested by the Relator revealed that during the last four months of 1994 alone Defendants approved claims to Medicare for over 1 million FUCPs, resulting in a loss to Medicare of over $7.4 million. (R 70, AC ¶113). That was especially disturbing in light of the fact that the Relator's investigation also had revealed that the only company making reimbursable FUCPs, Hollister, manufactured less than 20,000 FUCPs between 1993 and 1995. (R 70, AC ¶ 81.) The

claims payment data also revealed that the total payments for Code A4328 claims authorized by Defendants in 1995 was more than 25 times the amount of money paid by Medicare under that Code in 1992 for the entire United States. (R 70, AC ¶ 114.)

From the beginning of 1997 through the second quarter of 2000, Defendant Palmetto was virtually the only DMERC in the country approving any payments for FUCPs, paying 99.9% of all such claims on behalf of the Medicare program. (R 70, AC ¶¶ 116-122.) The Relator advised the Government of the Defendants' fraud and filed this action under seal on March 31, 1999. (R 70, AC ¶ 124.) The seal was partially lifted and on May 11, 2000, the Department of Justice sent the initial Complaint to the Defendants. Significantly, Defendants did not stop making payments for false claims for incontinence supplies until after the Government disclosed the contents of the Relator's initial Complaint to Defendants in May of 2000. (R 70, AC ¶ 140.) Immediately after being shown the Relator's Complaint, the Defendants did a complete about face and immediately began disapproving virtually all (almost 99%) of the FUCPs submitted to them for payment. (R 70, AC ¶ 140.)

After the Relator filed his initial Complaint, additional evidence of highly questionable claims processing activities by the Defendants came to light. See (R 70, Amended Complaint at ¶¶ 16-24). For example, one former employee of the Defendants provided a detailed affidavit describing Defendants' fraudulent claims processing activities. (R 70, Amended Complaint at ¶ 151). Moreover, one federal judge, presiding over a

different case where Palmetto authorized payment of over $140 million for patently fraudulent prosthetic claims, publicly commented that, given the Defendants' performance as a fiscal agent, "[i]t is unclear why Palmetto . . . is not a subject of the Government's investigation into criminal wrongdoing, in light of the overwhelming evidence covering months of losses in the millions." (R 70, Amended Complaint at ¶ 18).

REASONS FOR GRANTING THE PETITION

The Eleventh Circuit held that Palmetto, the DMERC, was protected by the absolute immunity established by an earlier Eleventh Circuit case involving a Part A Medicare Intermediary. Appendix A at 2, citing *United States ex rel. Body v. Blue Cross and Blue Shield of Ala., Inc.* 156 F.3d 1098, 1111 (11th Cir. 1998). Although the nature of the immunity addressing Medicare Part B Carriers (including the DMERCs) is contained in a separate statutory provision from the immunity addressing Medicare Part A Intermediaries, the language of the two statutory provisions is identical.

The *Body* Court reached its conclusion by contrasting the language of Subsection 1395h(i)(3) of the Medicare Law, the Subsection of the statute applicable to Part A Intermediaries, with the language of Subsections (1) and (2) dealing with the limited immunity provided to certifying officers and disbursing officers. As the *Body* Court stated,

> "[i]n contrast to the limited immunity accorded to certifying and disbursing officers, subsection 1395(i)(3) broadly states that the

> fiscal intermediaries themselves will not be liable to the government for any of the payments referred to in paragraphs (1) and (2) – that is, payments certified by certifying officers and disbursed by disbursing officers."

Id.

In contrast, however, in reversing a district court dismissal based entirely on the *Body* decision, the U.S. Court of Appeals for the Tenth Circuit addressed precisely the same immunity question and reached precisely the opposite conclusion.[4] *United States ex rel. Sikkenga v. Regence BlueCross BlueShield*, 472 F.3d 702, 709-711 (10th Cir. 2006). According to the Tenth Circuit (and the U.S. Department of Justice) the statutory language is unambiguous. *Sikkenga*, 472 F.3d at 710; Amicus Brief of United States Department of Justice in *United States ex rel. Sikkenga v. Regence Blue Cross Blue Shield of Utah*, at 7. "Correctly read, the payments referred to and incorporated by Section 1395u(e)(3) are payments made 'in the absence of gross negligence or intent to defraud the United States.'" *Id.*; See Amicus Brief of the United States Department of Justice in *United States ex rel Sikkenga v. Regence Blue Cross Blue Shield of Utah*, July 22, 2005, at 11.

There can be no question that *Body* was wrongly decided. Even if it could be argued that the statutory language is itself ambiguous, the legislative history plainly demonstrates that the Tenth Circuit's reading

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[4] *Body* construed a different section of the Medicare Act. However, the language of both sections is identical.

is correct. In the House Conference Report accompanying the passage of Section 1395u(e)(3), "the committee stated that *this provision provides carriers with 'the same immunity from liability for incorrect payments as would be provided their certifying and disbursing officers.'* H.R. Rep. No. 89-682, at 37 (1965) (Conf. Rep.) *as reprinted in* 1965 U.S.C.C.A.N. 1943, 2231." *Sikkenga*, 472 F.3d at 710-711 (emphasis added).

The Tenth Circuit explained that

> "[t]o the extent that our disagreement with the Eleventh Circuit can be said to evince ambiguity in the statute we find support for our interpretation in the legislative history of this provision. In the House Conference Report accompanying the passage of § 1395u(e) (3), the committee stated that this provision provides carriers with 'the same immunity from liability for incorrect payments as would be provided their certifying and disbursing officers. Thus, the legislative history unequivocally resolves any ambiguity that might exist because of the statute's poor grammatical structure. The immunity available . . . [to a] Medicare carrier under § 1395u(e)(3) is coextensive with that of its certifying and disbursing officers-in other words, the immunity excludes cases involving fraud and gross negligence." *Sikkenga*, 472 F.3d at 710-711 (internal citations, and quotations omitted).

The statutory language contained in a subsequent legislative enactment applicable to conduct undertaken subsequent to Oct. 1, 2005 explicitly reaffirms the statement of the contemporaneous legislative history cited by the Tenth Circuit. Specifically, Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which took effect on October 1, 2005 eliminated any possible ambiguity contained in the earlier enactment by explaining that "no Medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer *unless, in connection with such payment, the Medicare administrative contractor acted with reckless disregard of its obligations under its Medicare administrative contract or with intent to defraud the United States.*" Medicare Prescription Drug Improvement, and Modernization Act of 2003, § 911(d), Pub. L. No. 108-173, 117 Stat. 2066 (codified at 42 U.S.C. § 1395kk-1 (2003)) (emphasis added). The provision then goes even further stating that "[n]othing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of Title 31, United States Code." *Id.* Thus, Section 911(d)(3)(A) unambiguously provides that Medicare Contractors are to be granted only the same limited liability as certifying and disbursing officers, no more and no less. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 911(d).[5]

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[5] As a result of this later statute, Medicare contracting agents like the Defendant Palmetto are subject to legal challenge for any improper payments made to suppliers after October 1, 2005 to the extent those payments are made intentionally or recklessly.

Importantly, the comments of the bill's manager, Senator Grassley, on the Senate floor prior to passage of the 2003 amendment plainly indicate that the purpose of the amendment was to clarify, not change, existing law. 149 Cong. Rec. 15606 (2003). As Senator Grassley explained,

> "[t]he language contained in section 911 of the conference agreement clarifies that Medicare administrative contractors are not liable for inadvertent billing errors but, *as in the past*, are liable for all damages resulting from reckless disregard or intent to defraud the United States. . . . This legislation makes it clear that the False Claims Act continues, *as in the past*, to remain available as a remedy for fraud against Medicare by certifying officers, disbursing officers, and Medicare administrative contractors alike and that Medicare contractors are subject to administrative, as well as trust fund, damages."

Id. (emphasis added).

In light of the clear congressional policy against absolute immunity for Medicare contractors like the Defendants, it makes no sense to deprive the government and the taxpayers of an opportunity to recoup the fruits of the Defendants' fraud by granting them absolute immunity. "The Eleventh Circuit's decision in *Body* is wrong. . . ." Amicus Brief of the United States Department of Justice in *United States ex rel. Sikkenga v. Regence Blue Cross Blue Shield of Utah*, at 15. It should be reversed. Neither Part A Intermediaries nor Part B Carriers should be granted absolute statutory immunity when they recklessly or intentionally pay fraudulent claims.

Unless the Eleventh Circuit's Opinion is reversed, the federal government will be prevented from recovering the more than $40,000,000 in fraudulent payments that the Defendants made for FUCPs on behalf of the Medicare program. (R 126, AC ¶ 113.) Nor is the problem confined only to fraudulent payments for FUCPs, or self-correcting as a result of the statutory provision that became effective as of October 1, 2005. Indeed, the United States Department of Justice has recognized that, not withstanding the new statute, the issue of Medicare contractor liability "remains significant." (Amicus Brief of the United States Department of Justice in *United States ex rel. Sikkenga v. Regence Blue Cross Blue Shield of Utah*, July 22, 2005 at 20 n.7.)

In that regard, the significance of the Eleventh Circuit's incorrect interpretation of the applicable statute goes far beyond the $40,000,000 that will be lost to the federal government in this case, because historically Medicare fraud has been rampant, and many Medicare Carriers and Intermediaries, including DMERCs like the Defendants, have done precious little to identify or alleviate that fraud, particularly as it related to fraudulent claims for DME. In fact, the Medicare program has been the perfect target for fraud precisely because its agents (the Intermediaries and Carriers like the Defendants in this case) did so little to investigate. As one recent investigative story from National Public Radio ("NPR") explained:

> [I]t's a trusting system, set up to serve honest physicians — with few safeguards designed to weed out false claims. Also, most claims are paid automatically, so there's little or no person-to-person contact.

> The companies Medicare hires to handle its claims say they are working to improve fraud detection. But their main mission is not to root out fraud; it is to pay claims quickly and smoothly. ("Medicare Fraud Acute in South Florida," by Greg Allen, NPR Legal Affairs, October 11, 2007.)

As a recent report of the Office of Inspector General of the Department of Health and Human Services ("Medical Review of Claims For The Fiscal Year 2006 Comprehensive Error Rate Testing Program," Department of Health and Human Services, Office of Inspector General, August 2008 ("OIG Report")) noted, the Medicare program itself has acknowledged that Medicare made approximately $700,000,000 in improper Medicare payments for DME during the fiscal year beginning October 1, 2005, the first year that the new statute was in effect. (See OIG Report at 2). There is no reason to believe that fraudulent payments were any less prevalent during prior years. In fact, precisely the opposite is true. As the head of Program Integrity for the Medicare program explained in another recent NPR feature, "until recently CMS (the Medicare program) didn't actually look for fraud." ("Feds Fight Rampant Medicare Fraud in South Florida," by Greg Allen, NPR Legal Affairs, November 6, 2007 at 2.)

Moreover, the Inspector General's recent Report emphasized that the Medicare program's estimate of improper DME payments was significantly understated. (*See* OIG Report at 5). According to the Inspector General's Report, the actual error rate for DME payments alone during FY 2006 was almost four times

the rate acknowledged by the Medicare program itself, or approximately $2.8 billion. (See OIG Report at 5.) In reacting to the Inspector General's Report the Ranking Member of one congressional subcommittee singled out the Defendant Palmetto by name as an entity in need of additional oversight. (See September 3, 2008 Press Release of Senator Norm Coleman (http:hsgac.senate.gov/public/index.cfm?FuseAction=PressReleases.Detail&PressRelease_id=a73d82d9-523a-42d7-85b9-63cafb421965&Affiliation=R).)

Of course, Medicare fraud relating to DME is likely to be merely the tip of the iceberg. Some comprehensive estimates of Medicare fraud suggest that the total annual losses to the Medicare program could be far more than the $2.8 billion annual loss related to DME fraud estimated by the Inspector General, and, in fact, could be as high as $70 billion annually. (*See* "Medicare Fraud Acute in South Florida," by Greg Allen, NPR Legal Affairs, October 11, 2007 at 3.) Neither the government, nor the taxpayers should be expected to pay for losses that enormous. Plainly, those responsible, the agents of the Medicare program, Carriers and Intermediaries like the Defendants, should not be granted a free pass with respect to conduct that otherwise would be violative of the federal False Claims Act.

CONCLUSION

For the foregoing reasons the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

ATLEE W. WAMPLER, III
Counsel of Record
WAMPLER BUCHANAN WALKER
CHABROW BANCIELLA & STANLEY, P.A.
SunTrust International Center
Suite 1700
One Southeast Third Avenue
Miami, Florida 33131
(305) 577-0044

SIDNEY R. BERGER
Three First National Plaza
Suite 3700
70 West Madison Street
Chicago, Illinois 60602
(312) 558-6730

Counsel for Petitioners

APPENDIX

APPENDIX A — PER CURIAM OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT FILED MAY 20, 2008

UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

No. 07-11170

D.C. Docket No. 99-00938 CV-ASG

RICHARD FEINGOLD, individually and ex rel. United States of America, UNITED STATES OF AMERICA,

Plaintiffs-Appellants,

versus

PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS, JOHN DOE, etc.,

Defendants-Appellees.

Appeal from the United States District Court for the Southern District of Florida

(May 20, 2008)

Before ANDERSON, HULL and SILER,* Circuit Judges.

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* Honorable Eugene Siler, Jr., United States Circuit Judge for the Sixth Circuit, sitting by designation.

Appendix A

PER CURIAM:

After oral argument and careful consideration, we readily conclude that the judgment of the district court is due to be affirmed. With respect to Counts III and IV of the complaint, we conclude that we are bound by our prior panel opinion in *United States ex rel. Body v. Blue Cross and Blue Shield of Alabama, Inc.*, 156 F.3d 1098 (11th Cir.1998). Accordingly, defendants are immune with respect to the allegations of Counts III and IV.

With respect to Counts I and II, we conclude that the district court committed no reversible error in dismissing those counts for failure to comply with Fed.R.Civ.P. 9(b).

Accordingly, the judgment of the district court is

AFFIRMED.

APPENDIX B — ORDER GRANTING DEFENDANTS' MOTION TO DISMISS; CLOSING CASE OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA DATED JANUARY 30, 2007

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA CASE NO. 99-938-CIV-GOLD/TURNOFF

UNITED STATES OF AMERICA *ex rel.* RICHARD FEINGOLD,

Plaintiffs,

v.

PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS, BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA, AND UNKNOWN DURABLE MEDICAL EQUIPMENT SUPPLIERS,

Defendants.

ORDER GRANTING DEFENDANTS' MOTION TO DISMISS; CLOSING CASE

THIS CAUSE came on before the Court on Motion to Dismiss the Amended Complaint [**DE 84**], filed April 17, 2006.[1] The Motion to Dismiss is fully briefed. I held

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1. The Defendants moving to dismiss are Blue Cross and Blue Shield of South Carolina, and its wholly owned subsidiary, (Cont'd)

oral argument on the Motion to Dismiss on December 8, 2006. After reviewing the parties' briefs and applicable case law, and after hearing the parties' positions at oral argument, I grant Defendant's Motion to Dismiss the Amended Complaint with prejudice.

I. Facts

The relevant facts as alleged in the Amended Complaint, taken as true for purposes of considering a Motion to Dismiss, are as follows:

Richard Feingold, the Relator in this case, filed a Complaint against Palmetto pursuant to the *qui tam* provisions of the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3732 (1982). Feingold alleges that Palmetto recklessly approved false claims in violation of the FCA.

In January of 1993, Palmetto entered into a contract with the Centers for Medicare and Medicaid Services ("CMS")[2] to serve as one of four Durable Medical Equipment Regional Carriers (the "DMERC" contract).[3] (Amended Compl. at ¶ 28). The DMERC

(Cont'd)

Palmetto Government Benefits Administrator. Feingold originally named only Palmetto as a defendant, but later added Blue Cross. For convenience, these two Defendants will be referred to as "Palmetto."

2. CMS was formerly known as the Health Care Financing Administration (HCFA).

3. Palmetto also entered into two additional contracts with CMS, but those contracts are not at issue here.

contract provided that Palmetto would, beginning in approximately September, 1994, replace the Medicare carriers in 14 states, along with Puerto Rico and the Virgin Islands, and become the carrier with the responsibility of determining the propriety of Durable Medical Equipment Prosthetics Orthodontics Supplies ("DMEPOS") claims filed by suppliers under Medicare Part B for those areas. (*Id.* at ¶ 29). Under the contract, Palmetto was required perform administrative services including various anti-fraud checks to prevent the payment of fraudulent or false claims, and claims for medically unnecessary goods and services. (*Id.* at ¶ 31).

Feingold alleges that Palmetto failed to perform the required anti-fraud investigations, and that it failed to designate a certifying officer and/or a disbursing officer to administer claims payments. (*Id.* at ¶ 32). Feingold further alleges that Palmetto used false records or statements in various reports that were required for reimbursement under the Medicare program. (*Id.* at ¶ 33). Feingold also alleges that Palmetto knowingly utilized a computer program designed to override prepayment screens required by CMS, and that this program was deliberately used to elude detection of false claims. (*Id.* at ¶ 35).

Feingold claims that he is an original source of information relating to the fraudulent activities engaged in by Palmetto, as follows:

In the 1980's, Feingold had a home business supplying durable medical equipment, as well as a

medical claims billing company. (*Id.* at ¶¶ 70, 71). Through his business contacts, Feingold became aware of a company called "Bulldog" that was providing diapers to nursing home patients, and billing the supplies to Medicare. (*Id.* at ¶ 71). Bulldog offered Feingold a job, which he declined; instead Feingold began his own durable medical equipment company, "Illiana," which began operations in January, 1994. (*Id.* at ¶¶ 72, 74). On March 11, 1994, Feingold received a National Medicare Fraud Alert concerning improper billing and coding, and recognized that the alert pertained to the diapers that Illiana was providing, and receiving reimbursements from Medicare. (*Id.* at ¶ 75). Feingold's business partner contacted Administar, the region's carrier for DMEPOS claims, who informed him that Medicare would continue to pay their claims under the current code. (*Id.* at ¶ 76). Feingold then dissociated himself from the business. (*Id.* at ¶ 77).

Feingold then undertook an investigation regarding the use and supply of female urinary collection pouches (FUCPs). He interviewed nursing home directors and staff, and discovered that none of the health care professionals he spoke with had ever seen an FUCP used on a patient. Further investigation revealed that while various durable medical equipment suppliers were filing claims and being reimbursed for FUCPs, these items were not actually being provided. (*Id.* at ¶¶ 80-84). Instead, providers were supplying non-reimbursable, inexpensive diapers, and billing them under the code for the much more expensive FUCPs. (*Id.* at ¶ 84)

Appendix B

In May of 1994, Feingold filed a False Claims action against two companies, Bulldog and MLC Geriatric Health Services, which, through his investigation, Feingold knew to be fraudulently billing for FUCPs. As a result of this lawsuit, the government eventually received over $34 million from Bulldog. (*Id.* at ¶¶ 85-88). In July, 1994, Feingold filed a False Claims action against Illiana, his former company. (*Id.* at ¶ 89).

Between 1994 and 1995, five National Medicare Fraud Alerts were issued relating to fraudulent and improper billing for female diapers under the FUCP code. (*Id.* at ¶¶ 94-98). Then in 1998, Feingold read a newspaper article about two individuals who had been indicted for fraudulently billing Medicare for diapers in 1994 and 1995. (*Id.* at ¶ 100). Feingold obtained copies of the indictments against these individuals and discovered that the claims were filed under the same code that was the subject of the False Claims actions he had filed in 1994. Feingold filed suit against Administar, the carrier for the region, alleging that Administar had violated the False Claims Act by approving payment for the improperly coded bills. (*Id.* at ¶ 103). Feingold's case against Administar was dismissed. The district court found, and the appellate court affirmed the decision, that Feingold was not an original source of the information supporting the False Claims action against Administar. (*Id.* at ¶ 104).[4]

4. See United States ex rel. Richard Feingold v. Associated Insurance Companies, Inc., 2001 WL 1155250 (N.D. Ill. 2001); United States ex rel. Richard Feingold v. Associated Insurance Companies, Inc.., 324 F.3d 492 (7th Cir. 2003).

Appendix B

While the Administar case was pending, Feingold undertook an investigation on his own to discover more about fraudulent FUCP claims. Feingold requested information from an unnamed "Medicare computer operator," and over the course of several years received certain printouts concerning billing for FUCPs. (*Id.* at ¶¶ 105, 106). Feingold claims that through his analysis of these computer printouts-which he claims are non-public information-he was able to determine that beginning in approximately 1993, fraudulent billing for FUCP claims rose dramatically. (*Id.* at ¶¶ 108-111). His analysis also revealed that Palmetto had the most inflated approval rates for FUCPs. (*Id.* at ¶ 112). Feingold claims that he discovered that Palmetto had approved over $40 million in false claims for FUCPs to date. (*Id.* at ¶ 113).

Feingold claims that based upon his personal knowledge and experience, he was able to request pertinent, non-public information, analyze that information, and determine that Palmetto was improperly approving claims for FUCPs. (*Id.* at ¶ 124, 128). Feingold then faxed a letter and a draft of the current False Claims Act Complaint to the United States Department of Justice, and then filed his Complaint under seal on March 31, 1999. (*Id.* at ¶ 139). Feingold alleges that following the Palmetto's notification of this lawsuit, Palmetto stopped approving virtually all FUCP claims. (*Id.* at ¶ 146).

Feingold asserts that after he alerted federal authorities of Palmetto's fraudulent activities regarding

the FUCPs, the government began investigation into Palmetto's approval practices under other improper codes. (*Id.* at ¶ 148). Palmetto, alleges Feingold, not only approved improper claims, but created a claims processing scheme by which to bypass fraud screenings to be sure they would receive payment on fraudulent claims. (*Id.* at ¶ 151). Feingold claims that Palmetto continued to receive payment for performing administrative duties under its contract, but either did not perform those duties at all, or performed them in a recklessly inadequate fashion. (*Id.* at ¶ 152).

In Counts I and II of the Amended Complaint, Feingold alleges that Palmetto submitted false claims and made false statements in order to be paid for its administrative obligations under the contract, which Palmetto had failed to perform. In Counts III and IV, Feingold alleges that Palmetto knowingly presented false claims to Medicare for payment.

Feingold requests relief in the form of repayment to the United States for all claims improperly paid by Medicare, statutory triple damages, and civil penalties.

II. Standard of Review

A complaint cannot be dismissed under Rule 12(b)(6) of the Federal Rules of Civil Procedure, unless "it appears beyond a doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Marsh v. Butler County,* 268 F.3d 1014, 1022 (11th Cir.2001); *Roe v. Aware Woman Center for*

Choice, Inc., 253 F.3d 678, 683 (11th Cir.2001), *cert. denied*, 542 U.S. 920, 124 S.Ct. 2875, 159 L.Ed.2d 777 (2004) (stating that complaint should not be dismissed unless it is "clear that no relief could be granted under any set of facts that could be proved consistent with the allegations") (citations omitted). A complaint cannot be dismissed under rule 12(b)(6) even if "it may appear on the face of the pleadings that a recovery is very remote and unlikely." *Id.*

In determining whether to grant a motion to dismiss, the court must accept all the factual allegations in the complaint as true and evaluate all inferences derived from those facts in the light most favorable to the plaintiff. *See Hoffend v. Villa*, 261 F.3d 1148, 1150 (11th Cir.2001). Although the plaintiff is not held to a very high standard on a Rule 12(b)(6) motion, the plaintiff is still required to "allege some specific factual bases for those conclusions or face dismissal" of the claim. *Jackson v. Bellsouth Telecomm.*, 372 F.3d 1250, 1263 (11th Cir.2004).

Applying these well-established principles to the facts of this case, I grant the Motions to Dismiss.

III. Analysis

Palmetto argues four points in support of its Motion to Dismiss: (1) that it, as a carrier, enjoys absolute immunity from suit under the Medicare Act; (2) that because Feingold's lawsuit is based on public information, the False Claims Act's jurisdictional bar prohibits this suit; (3) that the decision in the

Administar case precludes this action;[5] and (4) that the Amended Complaint must be dismissed because Feingold has failed to plead fraud with specificity under Fed.R.Civ.P. 9(b).

I address only arguments two and four at this juncture. The remaining arguments are more properly addressed in a motion for summary judgment due to numerous issues of fact raised by the pleadings.

A. Immunity Under the Medicare Act

Palmetto argues that the Counts III and IV must be dismissed on the basis of statutory immunity under the Medicare Act.[6] The Act provides for limited liability under certain conditions for carriers:

> (e) Liability of certifying or disbursing officers or carriers.
>
> (1) No individual designated pursuant to a contract under this

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5. *See Feingold v. Associated Ins. Companies, Inc.*, 2001 WL 1155250 (N.D. Ill. 2001), *aff'd U.S. ex rel. Feingold v. AdminaStar Federal, Inc.*, 324 F.3d 492 (7th Cir. 2003).

6. Palmetto also urges the Court to dismiss Counts I and II based on statutory immunity, relying on *United States ex rel. Sarasola v. Aetna Life Ins. Co.*, 319 F.3d 1292 (11th Cir.2003). While *Sarasola* does create an uphill struggle for Feingold's claims of failure to perform services, it does not foreclose those claims entirely. I therefore decline to dismiss Counts I and II on the basis of statutory immunity.

> section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.
>
> (2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.
>
> (3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

42 USCS § 1395u(e).[7] Palmetto argues that the clear

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7. The Act has since been amended to replace the term "carrier," used to describe Medicare Part B providers, and "intermediary," which described Part A providers, with a broader and more generic term "Medical administrative contractor." See the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 911(d), Pub.L. No. 108-173, 117 Stat. 2066 (codified at 42 U.S.C. 1395kk-1 (2003)). The language describing the limits of immunity have also changed. However, because there is no indication that the amended statute(s) were

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language of the statute, along with Eleventh Circuit precedent, mandate that it be found immune from this lawsuit, citing *Body v. Blue Cross and Blue Shield of Alabama*, 156 F.3d 1098 (11th Cir.1998) and *Sarasola v. Aetna Life Ins. Co.*, 319 F.3d 1292 (11th Cir.2003). I agree with Palmetto's position.

In both *Body* and *Sarasola*, the Eleventh Circuit made clear that fiscal intermediaries such as Palmetto are immune from liability for any payments certified and disbursed by its officers:

> subsection 1395h(i)(3) broadly states that the fiscal intermediaries themselves will not be liable to the Government for *any* of the payments referred to in paragraphs (1) and (2)—that is, payments certified by certifying officers and disbursed by disbursing officers.

Body, 156 F.3d at 1111 (emphasis in original). This recognition of absolute immunity under the Act was reiterated in *Sarasola*:

> We held in *Body* that "fiscal intermediaries themselves will not be liable to the

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(Cont'd)

to have retroactive applicability, the version of the statute applicable here is that which was in effect at the time the alleged actions occurred. *See Langdraf v. USI Film Prods.*, 511 U.S. 244, 114 S.Ct. 1483, 128 L.Ed.2d 229 (1994)(presumption against retroactivity may be overcome only be "clear congressional intent"). The applicable language is recited above.

> Government for *any* of the payments . . . certified by [its] certifying officers and disbursed by disbursing officers." 156 F.3d at 1111. This absolute immunity was, we held, a recognition of the unique administrative function that fiscal intermediaries play in the operation of the Medicare system and Congress's unwillingness to impose liability for the vast amounts of federal money they disburse.

Sarasola, 319 F.3d at 1302.

Feingold attempts to circumvent the Eleventh Circuit's holding in two ways: first, he alleges that Palmetto did not designate either certifying officers or disbursing officers; and second, he argues that the holding in *Body* and *Sarasola* is limited to Medicare Part A carriers, and does not extend to Part B carriers.

1. Failure to Designate Officers

Feingold alleges in his Amended Complaint that Palmetto failed to designate either certifying or disbursing officers to administer payments. Specifically, he alleges that

> Indeed, on information and belief, the Government Contractor Defendants even failed to perform the rudimentary function of designating a certifying officer and/or a disbursing officer as set out in the Contract

> and statutory scheme to administer claims to be paid to suppliers under Part B of the Medicare Program.

(Compl.¶ 32). Feingold claims that this failure to designate certifying and/or disbursing officers excludes Palmetto from the Act's immunity protections. Palmetto counters that Feingold's bald and unsupported allegation cannot stand under Eleventh Circuit standards. Palmetto points out that Feingold's allegation as to the failure to designate officers is merely "on information and belief," and is not supported by a single evidentiary or factual allegation with any particularity.[8]

The Eleventh Circuit has made clear that "conclusory allegations, unwarranted deductions of facts or legal conclusions masquerading as facts will not prevent dismissal." *Oxford Asset Mgmt. v. Jaharis,* 297 F.3d 1182, 1188 (11th Cir.2002), citing *South Florida Water Management Dist. v. Montalvo,* 84 F.3d 402, 406 (11th Cir.1996); *Fernandez-Montes v. Allied Pilots Ass'n,* 987 F.2d 278, 284 (5th Cir.1993).

In this case, Feingold makes the allegation that Palmetto did not designate a certifying and/or disbursing officer. However, Feingold has no factual basis whatsoever for that allegation; as noted, it is made merely "on information and belief." As Feingold has no insider knowledge of the manner in which Palmetto

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8. See discussion on the need to plead fraud with particularity at pages 11-16, *supra.*

conducted business, he has no basis for this bald allegation. It appears that the Feingold, knowing the Eleventh Circuit's precedent in *Body* and *Sarasola* as to immunity under the False Claims Act, is simply trying to avoid dismissal by the inclusion of this conclusory statement. This unsupported allegation will not exclude Palmetto from the False Claims Act's immunity defense.

2. Immunity for Part A vs. Part B Carriers

Palmetto attempts to distinguish *Body* and *Sarasola* from the case at hand on the grounds that both *Body* and *Sarasola* involved Part A intermediaries, whereas this case involves a Part B carrier. This argument fails, for the distinction is meaningless.

The language in the immunity provisions in the Medicare Act for Part A intermediaries (42 U.S.C § 1395h(i)), and for Part B carriers (42 U.S.C. § 1395u(e)) is virtually identical. The *only* difference in the two sections is that the Part A immunity provisions provides that "[n]o such **agency or organization** shall be liable," whereas the Part B immunity provision provides that "no such **carrier** shall be liable." Moreover, courts have consistently treated Part A and Part B carriers in the same fashion. *See, e.g., Body,* 156 F.3d at 1106 n. 17 (a carrier is "the Part B equivalent of a fiscal intermediary"); *U.S. ex rel. Rahman v. Oncology Associates, P.C.*, 198 F.3d 502, 512 n. 2 (4th Cir.1999) ("Fiscal intermediaries and carriers perform comparable roles . . . Courts have treated them in the same way").

Given the unambiguous, identical language of the immunity provisions, and the comparable treatment of Part A and Part B carriers by the courts, there is no reason to believe that the precedents established in *Body* and *Sarasola* are not applicable in this case. Palmetto, therefore, is protected by the False Claims Act's immunity provisions, and shall suffer no liability for any improper payments which might have been made. Count III and IV—alleging improper payment of claims—must therefore be dismissed.

B. Failure to Plead Fraud with Specificity

Palmetto moves to dismiss all counts for failure to plead fraud with specificity. Generally, federal civil complaints need only state "a short and plain statement of the claim showing that the pleader is entitled to relief," Fed.R.Civ.P. 8(a), and each averment should be "simple, concise, and direct," with no technical form of pleading required. Fed.R.Civ.P. 8(e). However, "in all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally." Fed.R.Civ.P. 9(b). *United States ex rel. Clausen v. Lab. Corp. of Am.*, 290 F.3d 1301, 1308 (11th Cir.2002).

FCA claims must be stated with particularity pursuant to Rule 9(b). *See Clausen*, 290 F.3d at 1308 ("Rule 9(b) [applies] to actions under the False Claims Act"). Particularity means that "a plaintiff must plead 'facts as to time, place, and substance of the defendant's

alleged fraud,' specifically 'the details of the defendant['s] allegedly fraudulent acts, when they occurred, and who engaged in them." *United States ex rel. Atkins v. McInteer*, 470 F.3d 1350 (11th Cir.2006); *Clausen*, 290 F.3d at 1310 quoting *Cooper v. Blue Cross & Blue Shield of Fla., Inc.*, 19 F.3d 562, 567-68 (11th Cir.1994). In *Atkins*, the Eleventh Circuit explained that

> Rule 9(b)'s directive that "the circumstances constituting fraud or mistake shall be stated with particularity" does not permit a False Claims Act plaintiff merely to describe a private scheme in detail but then to allege simply and without any stated reason for his belief that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government.
>
> We cannot make assumptions about a False Claims Act defendant's submission of actual claims to the Government without stripping all meaning from Rule 9(b)'s requirement of specificity or ignoring that the "true essence of the fraud" of a False Claims Act action involves an actual claim for payment and not just a preparatory scheme.

Atkins, 470 F.3d at 1357, citing *Clausen*, 290 F.3d at 1311 (quoting Rule 9(b)). The court emphasized that "if Rule 9(b) is to be adhered to, some indicia of reliability must

be given in the complaint to support the allegation of an actual false claim for payment being made to the Government." *Id.*

In both *Clausen* and *Atkins*, the district courts dismissed the relators' claims on the grounds that the relators had failed to allege any specific facts to demonstrate that the defendants actually submitted false claims to the government. The relators in those cases described in great detail the fraudulent scheme itself, but were unable to provide a single concrete allegation describing the submission of a false claim. The court distinguished the facts of both *Clausen* and *Atkins* from *Hill v. Morehouse Med. Assoc., Inc.*, 82 Fed.Appx. 213, 2003 WL 22019936 (11th Cir.2003), in which a relator's claims withstood dismissal. In *Hill*, the relator had

> firsthand information about the [defendant's] internal billing practices and the manner in which the fraudulent billing schemes were implemented. Moreover, she alleged that she observed [the defendant's] billers, coders, and physicians alter various CPT and diagnosis codes over the course of [her] seven months and thus submit false claims for . . . reimbursement to the government. . . . Most important, . . . unlike the plaintiff in [Clausen], [the Hill plaintiff] was privy to [the defendant's] files, computer systems, and internal billing practices . . . because she worked in [the defendant's] billing and coding department for seven months.

Appendix B

The Eleventh Circuit described the scenario in *Atkins* as follows:

> In the case at hand, the complaint fails rule 9(b) for want of sufficient indicia of reliability to support the assertion that the defendants submitted false claims. As the plaintiff did in *Clausen,* Atkins has described in detail what he believes is an elaborate scheme for defrauding the government by submitting false claims. He cites particular patients, dates and corresponding medical records for services that he contends were not eligible for government reimbursement. Just like the *Clausen* plaintiff, though, Atkins fails to provide the next link in the FCA liability chain: showing that the defendants actually submitted reimbursement claims for the services he describes. Instead, he portrays the scheme and then summarily concludes that the defendants submitted false claims to the government for reimbursement.
>
> In his complaint, Atkins does not profess to have firsthand knowledge of the defendants' submission of false claims. He is a psychiatrist responsible for the provision of medical care, not a billing and coding administrator responsible for filing and submitting the defendants' claims for reimbursement. He rotated through a single facility where he heard rumors from staff and observed

> records of what he believed to be the shoddy medical and business practices of two other psychiatrists. He then brought suit against those two psychiatrists, their company, and the SNF's where, he alleges, those two psychiatrists had provided psychiatric care over a three-year period.
>
> The Hill relator, by contrast, personally observed the behavior of which she complained during the seven months she spent in her employer's billing and coding department, and then brought her action against her employer. Atkins's complaint not only fails to contain an indicia of reliability approaching the level of reliability found in the Hill allegations, it sweeps with a much broader brush by naming as defendants SNF's into which Atkins never stepped foot. Faced with these pleading deficiencies, we would be hard pressed to say that Atkins's complaint satisfies the particularity requirement of Rule 9(b).

The facts at hand are remarkably similar to those found in *Clausen* and *Atkins*.[9] Feingold here has no

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9. Also similar to *Clausen*, Feingold is a multiple filer. The Eleventh Circuit noted that "We find it ironic that Clausen was himself a relator in *LaCorte*, in which the Third Circuit barred him from bringing a lawsuit against SmithKline Beecham regarding medical testing after a similar, but not identical, (Cont'd)

firsthand knowledge of any fraudulent conduct on the part of Palmetto. Feingold never worked for or with Palmetto, nor did he ever submit any false claims to Palmetto which were subsequently approved by Palmetto. Feingold argues that he embarked upon an investigation by which he uncovered Palmetto's fraudulent scheme, but he is able to demonstrate only generalities.

In his Complaint, consisting of 214 paragraphs over 116 pages, Feingold includes a wealth of information concerning the history of the FUCP scheme. He similarly provides an abundance of allegations concerning the ways in which claims are processed and submitted from health care providers to carriers, and from carriers to the government. He fails, however, to point so specific examples of fraudulent claims approved or submitted by Palmetto. In his Complaint, Feingold engages in a lengthy discussion of various fraudulent statements allegedly made by Palmetto in reports submitted in 1995, and he references "Exhibit Q" of the Complaint (Compl.¶ 178). Exhibit Q, however, is the "Carriers Manual," which is available from a

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lawsuit had already been brought. 149 F.3d at 237. In rejecting Clausen's argument that the decision in *LaCorte* would lead to relators pleading a 'very broad cause of action so as to preempt claims by later plaintiffs,' the Third Circuit observed that Rule 9(b) 'provides sufficient deterrence against overly broad allegations.' " *Clausen*, 290 F.3d 1301. In the case at hand, as in *Clausen*, Rule 9(b) works to prohibit a lawsuit based upon the broad and generalized allegations brought by a multiple relator.

government manual website. Exhibit Q is not an actual report submitted by Palmetto to the government with false statements. Rather, it is a guideline manual which explains what specific information is required on various reports that carriers submit to the government. Feingold then extrapolates that Palmetto *must* have submitted fraudulent reports, because FUCP fraud was rampant at that time. He fails, however, to identify or produce a single fraudulent claim form or report prepared by Palmetto.

Because of his earlier experience at Illiana, where he personally observed the submission and payment of fraudulent FUCP claims, Feingold has reason to believe that the fraudulent practices are industry wide. However, a reason to believe that fraud is occurring is far from sufficient to withstand dismissal under the rigorous standards of Rule 9(b), particularly in light of the recent Eleventh Circuit cases dismissing comparable *qui tam* actions. As the court explained, "The particularity requirement of Rule 9 is a nullity if Plaintiff gets a ticket to the discovery process without identifying a single claim." *Atkins*, 470 F.3d at 1359. Citing *Clausen*, the court reasoned that

> If given such a ticket, the next stage of [the] litigation is clear. The Plaintiff will request production of every . . . claim submitted by the Defendant [during the time period corresponding to Plaintiff's claims]. At that point, the Defendant may decide to settle the case to avoid the enormous cost of such

> discovery and the possible disruption of its ongoing business. On the other hand, the Defendant may choose to resist the discovery. In that case, the Court will be presented with the dilemma of allowing an unlimited fishing expedition or no discovery at all because of the difficulty in fashioning logical and principled limits on what has to be produced. The particularity requirement of Rule 9(b), if enforced, will not only protect defendants against strike suits, but will result in claims with discernable boundaries and manageable discovery limits.
>
> *United States ex rel. Clausen v. Lab. Corp. of Am.*, 198 F.R.D. 560, 564 (N.D.Ga.2000), aff'd, 290 F.3d 1301 (11th Cir.2002).
>
> Requiring relators to plead FCA claims with particularity is especially important in light of the quasi-criminal nature of FCA violations (i.e., a violator is liable for treble damages). Rule 9(b) ensures that the relator's strong financial incentive to bring an FCA claim—the possibility of recovering between fifteen and thirty percent of a treble damages award—does not precipitate the filing of frivolous suits.

Atkins, 470 F.3d at 1359.

Appendix B

As the court noted in Feingold's *Administar* case, Feingold made a considerable sum of money as a result of his initial *qui tam* actions. *See United States ex rel. Feingold v. Administrar, Inc.*, 2001 WL 1155250, at *1 (N.D.Ill.2001). Clearly, he has had a financial incentive to repeat that success. However, Feingold was in a position to bring the initial lawsuit against Illiana and Bulldog as an appropriate relator: he had specific factual evidence of the fraud, and he was an original source of the information. That is the sort of claim that the laws surrounding *qui tarn* suits are designed to permit, and to reward. However, when a relator seeks to repeat earlier financial success by filing an action based simply on a supposition that other entities are involved in similar fraudulent activities, that is the sort of "parasitic" lawsuit which the False Claims Act is designed to prohibit.[10]

Under the well-established standards of the Eleventh Circuit, Feingold has failed to plead fraud with particularity sufficient to withstand dismissal. Accordingly, Feingold's Complaint must be dismissed.

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10. *See, e.g., Cooper v. Blue Cross & Blue Shield*, 19 F.3d 562 (11th Cir.1994)(discussing the False Claims Act's *qui tam* provisions to prevent parasitic lawsuits); *Walburn v. Lockheed Martin Corp.*, 431 F.3d 966 (6th Cir.2005)(same); *United States ex rel. Atkinson v. Pa. Shipbuilding Co.*, 473 F.3d 506, 2007 U.S.App. LEXIS 708 (3d Cir.2007)(same); *United States ex rel. Karvelas v. Melrose-Wakefield Hosp.*, 360 F.3d 220 (1st Cir.2004) (same).

C. Leave to Amend

Feingold has not requested that, should I dismiss his Complaint, he be granted leave to amend. However, I anticipate that he will make such a request, and therefore address the issue now.

Federal Rule of Civil Procedure 15(a) states that leave to amend "shall be freely given when justice so requires." Fed.R.Civ.P. 15(a); *Pioneer Metals, Inc. v. Univar USA, Inc.*, 168 Fed.Appx. 335, 336-337, 2006 WL 353465 (11th Cir.2006). "Unless there is a substantial reason to deny leave to amend, the discretion of the district court is not broad enough to permit denial." *Id.*, citing *Thomas v. Town of Davie*, 847 F.2d 771, 773 (11th Cir.1988) (quoting *Dussouy v. Gulf Coast Inv. Corp.*, 660 F.2d 594, 598 (5th Cir.1981)). The Supreme Court has emphasized that leave to amend *must* be granted absent a specific, significant reason for denial. *Foman v. Davis*, 371 U.S. 178, 182, 83 S.Ct. 227, 9 L.Ed.2d 222 (1962). The permissible reasons that can justify denial of leave to amend include "undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party . . . [, and] futility of amendment. . . ." *Pioneer Metals*, 168 Fed.Appx. at 336-337. The justifying reason must be either explicitly declared or apparent. *Id.* The Eleventh Circuit has indicated that it views with great distaste district court denials of amendments without stated reasons. *Id.*, citing *Rhodes v. Amarillo Hosp. Dist.*, 654 F.2d 1148, 1153-1154 (5th Cir.1981).

In this case, I will dismiss Feingold's Complaint with prejudice, denying leave to amend on the basis of futility. Feingold has, at this point, filed at least five *qui tam* actions. As discussed above, his two initial lawsuits were based upon information that he garnered by having personal knowledge of the ongoing fraud. Since then, however, Feingold has initiated at least three *qui tam* suits alleging facts of which he has had no personal knowledge. He has clearly educated himself on how to plead to avoid certain obvious deficiencies; his latest action attempts to avoid every basis for dismissal in *Administar*, as well as deficiencies found by other courts in *qui tam* actions brought by other relators. Nonetheless, Feingold has failed to state a cause of action against Palmetto in this case. Given the fact that Feingold is a repeat filer who is not an insider of Palmetto, and because he has no personal knowledge of Palmetto's claims procedures, there are no circumstances under which Feingold could amend his Complaint to cure the deficiencies therein.

IV. Conclusion

Because I find dismissal appropriate on the bases of the False Claims Act's immunity provisions as well as the Complaint's incurable failure to plead fraud with specificity, I need not address Palmetto's remaining arguments for dismissal: issue preclusion based on the

Administar holding, and the jurisdictional public disclosure bar.[11]

Accordingly, it is hereby **ORDERED and ADJUDGED** that:

1. Defendants' Motion to Dismiss the Amended Complaint [**DE 84**] is **GRANTED, with prejudice.**

2. Counts III and IV are dismissed based upon statutory immunity under the Medicare Act.

3. Counts I through IV are dismissed based upon Plaintiff's failure to plead fraud with specificity.

4. This case is CLOSED.

5. All pending motions are DENIED as moot.

DONE AND ORDERED, in Chambers, in Miami, Florida, this 30 day of January, 2007.

s/ Alan S. Gold
UNITED STATES DISTRICT COURT
HON. ALAN S. GOLD

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11. I also point out that, in order to rule on Palmetto's public disclosure argument, it would have been necessary to convert this motion to dismiss into a motion for summary judgment, which I decline to do at this juncture.

APPENDIX C — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DENYING PETITION FOR REHEARING FILED JULY 18, 2008

IN THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

No. 07-11170-JJ

RICHARD FEINGOLD, individually and ex rel. United States of America, UNITED STATES OF AMERICA,

Plaintiffs-Appellants,

versus

PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS, JOHN DOE, JANE DOE, BLUE CROSS AND BLUE OF SOUTH CAROLINA, CORPORATION, UNKNOWN DURABLE MEDICAL EQUIPMENT SUPPLIERS,

Defendants-Appellees.

On Appeal from the United States District Court for the Southern District of Florida

ON PETITION(S) FOR REHEARING AND PETITION(S) FOR REHEARING EN BANC

Appendix C

Before: ANDERSON, HULL and SILER,* Circuit Judges.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

s/ Hull
UNITED STATES CIRCUIT JUDGE

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* Honorable Eugene Siler, Jr., United States Circuit Judge for the Sixth Circuit, sitting by designation.